Dialogue at Work

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2014

document version
Publisher's PDF, also known as Version of record

Summary

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Over the past years, methods of clinical ethics support (CES) have developed and changed in terms of their organization and characteristics. This change was particularly influenced by the upcoming care-ethical theories of the 1990s. Changing views on ethics supported the idea that moral issues should not only be processed through ethics experts (such as ethics committees), but acknowledge the actual experience of morality in daily healthcare and the moral expertise of the work floor. The changes in thinking about morality in daily healthcare resulted in methods of ethics support that included the voice of those directly involved in the moral issues. It resulted in an increase of deliberative methods of CES, such as moral case deliberation (MCD). In Dutch healthcare MCD has become more and more common over the years.

This thesis follows, evaluates and describes the process of implementing MCD in a large mental healthcare institution in the eastern part of the Netherlands, called GGNet. The study pictures aspects of the implementation of MCD in a dialogical way. Throughout its evaluation, there is a consistent decision to understand MCD's implementation from the perspectives of those who are directly involved in the practice and organization of MCD. Their experiences relate to participation in actual MCD sessions, supportive practices of MCD, facilitating MCD and organizing MCD.

Chapter 1

Introducing Dialogue at Work

The first chapter introduces MCD, its origins and theoretical background and describes the practice of an MCD session. It also describes the development of CES, in which since the 1990s increased attention has been paid to 'everyday ethics': moral experiences of employees directly on the work floor. In this thesis, MCD is bound to a hermeneutic, dialectical vision of ethics in which dialogue is the means and outcome of an MCD session. This implies that the concrete experience of the moral issue, the joint exploration of diversity in perspectives, and a joint learning process are central aims in the practice of MCD. Together, these processes are methodically brought together in the concept of 'dialogue'.

An MCD session is a group conversation between healthcare employees (who may or may not work in direct patient care) in which one authentic case and one single moral question are central. Applying a methodical, disciplined conversation structure supports the realization of a dialogue. The facilitator of the session is specifically trained and has no connection with the content of the session. A dialogue is distinctive from a debate, conflict or discussion: all steps are directed towards a thorough mutual understanding via asking questions rather than convincing others of a particular standpoint. Presuppositions are systematically questioned to check their validity in relation to the facts of the case. MCD is characterized by trustworthiness, confidentiality, mutual openness, (moral) equality.

Considering the dialogical qualifications and characteristics of MCD, the startingpoint of this thesis was that the implementation of MCD should also contain a dialogical structure. This meant we would remain loyal to the characteristics of the practice of MCD, so that the implementation process of MCD would be in congruence with the dialogical aims of MCD itself, thereby striving for a shared ownership over MCD among its users. This is in line with current insights on leadership, striving for an active role of professionals in implementation processes.

The above considerations resulted in the decision to merge the characteristics of our research design with the aim for dialogue. Responsive evaluation is closely connected to the characteristics of the practice of MCD. After this decision, a threefold application of the concept of dialogue became visible in this thesis: in the practice of MCD, in its implementation process, and in the research on implementing MCD. Based on these initial considerations, three central research questions were formulated:

1 What is the role of dialogue in MCD?
2 What is the role of dialogue in the process of implementing MCD?
3 To what extent does responsive evaluation as dialogue contribute to the implementation of MCD?

Chapter 2

Implicit and explicit clinical ethics support

Chapter 2 provides an overview of the several methods of CES in Dutch healthcare institutions. These may either be explicit (structured, institutionalized attention to moral issues including professional facilitation) or implicit ('organic' attention to moral issues that arise during peer supervision, team meetings, patient discussions, on the fly or during coffee breaks, etcetera). In the study diverse healthcare contexts were included: hospitals, residential homes for the elderly, care institutions for (mentally) disabled people and mental healthcare.

Findings show that ethics committees are common in the Netherlands – in particular in hospitals. Roughly half of the Dutch care institutions have MCD, apart from mental healthcare institutions: almost two-thirds of those institutions have MCD. Ethics consultants are not very common in Dutch healthcare.

The study findings show that explicit attention to moral issues is considered important, yet acknowledgement of implicit ways of dealing with moral issues is necessary. Explicit CES are generally combined with implicit ways of CES. MCD, with a clear structure and at the same time possessing specific characteristics that leave room for authenticity and searching, may form a bridge between explicit and implicit ways of dealing with moral issues.

Chapter 3

Managers and moral case deliberation

Chapter 3 describes the relation and experiences of managers who initiate MCD in their teams. Mostly these are managers of nursing teams, although within GGNet other teams also have MCD: Human Resource Management, services, secretary, board of directors or gardeners of the institution. The paper describes why managers initiate MCD, how they relate to MCD, what their expectations are regarding MCD and how they relate to the outcomes of MCD in daily practice. By means of a managers' focus group these issues were investigated.

The findings showed that managers perceive MCD as *training* that teaches employees to communicate and cooperate in alternative ways. MCD supports critical thinking and paves the way for a critical-constructive approach by colleagues. MCD is the place at which employees are not primarily empathic but straightforward. In the perception of the managers, MCD as training contributes to the way in which team members relate to each other, thereby influencing the ward climate in daily practice. Considering the explorative space and methodical structure that is offered in MCD, managers perceive MCD as an informal, non-committal orientation on moral issues

from practice, and at the same time as formal, focused communication and cooperative training.

The informal and formal status of MCD results in a search by managers on how to organize MCD. Their concern regarding the organization of MCD also refers to the process-related outcomes of MCD. Although they are convinced that moral reflection is a necessary competence of employees, the outcomes of a session are not considered measurable. Managers struggle with these process-related outcomes, because they do not want to influence the content of the sessions; at most they wish to be able to manage the outcomes. But because this output depends fully on the process of the experiences *during* the MCD session, it is practically impossible to influence the outcomes of MCD.

Another important finding of the study is the question whether or not – and to what extent –managers should participate in MCD. Some of the managers firmly stated they would never participate: they consider MCD as nurses' domain and fear that their presence may obstruct the openness between the other participants. Some managers also think that their presence would prevent the team members assuming responsibilities themselves and they would refer them to their manager. With this decision, the manager nevertheless her/himself outside the team. Regarding the cooperative aims that managers formulate for MCD, this may be considered a paradox: although the team should improve its cooperation and communication, the team remains incomplete in the absence of the manager. Lessons learnt will therefore not reach the top of the team

Other managers eagerly do join the MCD sessions. Their presence shows the team members that moral issues also matter to them and that they are intrinsically part of the process of dealing with those moral issues. Yet participating in MCD brings dilemmas for the manager that coincide with MCD's characteristics: confidentiality, openness, vulnerability. Managers wonder for example if they may use information heard during MCD outside the sessions.

The findings show that managers search for how to relate to MCD, not only in terms of their organizational, facilitative tasks but also in terms of their identity. They have issues regarding confidentiality, vulnerability, openness and integrity. The findings of this study highlight management strategies that fit in the framework of a transformative and participative leadership, which focuses on a connection between organizational and personal values. An cooperative attitude results in a two-way process that results in shared ownership, shared inspiration, motivation and responsibility. As regards the organization of MCD, this may be an interesting perspective on leadership.

From our findings we conclude that the organization of MCD can therefore mean explorative space for transformative or participative management, as the manager

learns how to deal with the introduction of a new instrument without knowing what this instrument may result into. If the manager decides to join the sessions, there may be occasion for immediate equal deliberation, in which the meaning of working in an institution is shared in a context of joint learning processes.

Chapter 4

Local moral case deliberation coordinators

In Chapter 4, bottom-up involvement in organizing MCD is addressed by means of the introduction of local MCD coordinators. Local MCD coordinators are members of a team in which MCD takes place. Usually they are nurses. The tasks of local coordinators concern a relatively small part of their normal job, but given the findings of our study, their work is of great relevance for the implementation of MCD. The findings of the study show that local MCD coordinators have no ideological bonding with MCD. They generally find it difficult to explain to colleagues exactly what MCD is and highlight the importance of the experience of MCD: one must undergo the session to understand what MCD is about. Although MCD often comes with heavy terms such as 'ethics', 'deliberation', 'morality', 'values', 'norms', the local coordinator perceives MCD primarily as a refreshing way of meeting others, particularly other disciplines.

Local coordinators show that MCD needs a pragmatic organizational approach. There needs to be clarity about expectations and scheduling, and presence of multiple disciplines is required to optimize harvest. Team members are, from the perspective of loyalty, more likely to join sessions. This way, and by their eagerness to succeed in their efforts on bringing people together for an MCD session, local coordinators are dedicated to applying their pragmatic organizational tasks.

The study on local coordinators and bottom-up involvement in organizing MCD is informative in many ways. First, it shows the importance of bottom-up involvement in the organization of MCD. Such efforts contribute to the continuation of MCD in the team. As experience proceeds, they start co-owning MCD together with management and team. This contributes to their proactive interference. The pragmatic attitude of local coordinators teaches ethicists that MCD requires practical activities which are important for MCD's implementation. They show, by means of practical orientation, how to make ethics operational.

Yet the tasks of the local coordinators are typically the kind of activities that are easily overlooked or under-appreciated because of their self-evidence. In this study, we mark this type of activity as 'invisible work'. Highlighting the experiences and specific organizational expertise of local coordinators explicates the value of their contribution to MCD. In turn, this results in increasing proactivity by the local coordinators:

a catalyst that works both ways.

Second, it was learnt that this 'bottom-up ownership' of local coordinators helps other members of the team to experience MCD as something that is theirs, rather than some initiative of the manager. In this process the local coordinator nevertheless needs to take care that MCD is enduringly perceived as a team instrument. If s/he is not able to achieve this, MCD might then be perceived as something owned by the local coordinator. From experiences like these, it was learnt that MCD cannot do without top-down interference.

Finally, it was learnt that MCD (or CES in a broader context) cannot come from ideological involvement alone. The conviction that ethics is necessary for its own sake narrows the opportunity for MCD to develop. The study among local coordinators can be understood as a plea for a broadening from top-down, to top-down ànd bottom-up. A pragmatic approach on organizing MCD is preconditional for a durable continuation of sessions with motivated people from the work floor. Hence, the study shows that meaning does not come from predefined ideological considerations but that the meaning of MCD arises from the experiences of those involved in (the organization of) MCD.

Because MCD interferes with the local context in which the sessions take place, it is important to include others in the organization of MCD as well as the ethics functionary. In this context, the value and usefulness of MCD are clarified and co-ownership is felt. This is not only important for practical reasons but also for moral reasons: in the end, it is *their* context that is brought into motion via MCD. For that reason, a democratic modus of organizing and implementing MCD is a justified choice.

Chapter 5

Aims and harvest of moral case deliberation

In ethics practice, many questions are asked about the outcomes of MCD. Written institutional documents on MCD often suggest that MCD will contribute to better care and improvement of job satisfaction. Chapter 5 of this thesis presents the aims that managers formulate for MCD on the one hand and the experienced outcomes ('harvest' we call it) regarding the participants on the other. This study, for which a natural data collection strategy was applied, showed that managers primarily perceive MCD as training on cooperation and communication. They expect that MCD will contribute to the development of a critical attitude towards daily practice instead of staff slipping into old routines without thinking. But managers also note MCD as a way to regenerate nurses and take care of them. In MCD nurses are able to express experiences that had great impact on them personally or on the team. Moreover, MCD provides the

opportunity to regain sight onto the uniqueness of the nursing job and profession. Managers also believe that nurses tend to talk to each other from empathy, which diminishes their critical view on practice. MCD contributes to open, clear and critical feedback. Managers further consider MCD an instrument to improve care.

Examples coming from the 'harvest' of participants particularly refer to an increase at the level of cooperation, direct and clear communication and finding mutual support. They become aware of the burden of their job, and therefore the need for collective reflection. Further, participants noted an element of empowerment, particularly towards other disciplines. Quality of care was another aspect that participants considered as harvest of MCD. Some nurses also wrote that they learnt 'nothing' in MCD. Because of the autonomous processing of the evaluation questionnaires, it is not possible to fully understand what they meant by this, but we do think that for reasons of completeness it is important to mention this category also.

The categories of managers and participants do differ, but there are also some striking similarities. Both aims and harvest generally notified the *process* of MCD as most beneficial, rather than concrete outcomes or expectations or a focus on moral development related to the content of the session. Another important finding was that there were few aims and little outcome in terms of the quality of care. Our final finding concerns the opportunity to understand the organization of MCD as a chance for dialogical management practice. Through the research process we came to understand that generally information on neither aims nor harvest is exchanged between manager and team. As a result, the team possibly did not understand why MCD was being introduced, whereas the manager did not know what lessons came out of a session.

The study concludes that a key word in both aims and harvest is 'togetherness'. It expresses the eagerness and the necessity for team bonding and intensified cooperation. The concrete, experience-based outcome of the nurses has shown that nurses have innovative and practical ideas on how to improve daily practice – just like the manager intended with MCD. If therefore information on aims and harvest is exchanged on a regular basis between manager and team, this may result in an increasing co-ownership of practice changes that directly contribute to the improvement of ward issues and a cooperative climate.

Chapter 6

Client participation in moral case deliberation

In contrast with the former chapters of the thesis, this sixth chapter probes the practice of MCD: the practice of realizing a dialogue. Specifically this study focuses on

dynamics in transdisciplinary groups, in which not only professionals participate but also clients. To understand what is needed to implement MCD, it was necessary to see which dynamics are at stake during MCD itself. MCD in a transdisciplinary group can, according to our vision of MCD, be perceived as a dialogical aspiration optima forma. Perspectives that are often neglected, and groups that do not have a self-evident voice in moral decision-making processes, claimed an equal part in these MCD's. MCD's with clients or family participants implied doing justice to inclusion and equality. Within the institutional MCD steering group of GGNet this initiative was therefore acclaimed. The steering group nevertheless decided not to give a 'go' or 'no-go' signal but agreed to support and monitor the process. The reason for this (normative) reticence was to optimize the ownership of MCD in practice. Appointing an institutional owner of this project, for example the MCD steering group, would be in conflict with the startingpoint that refers to the hermeneutic-dialectical foundations of MCD in which the actual experience decides the assignment of meaning over that practice.

So, simultaneously with the request for client participation in MCD, a study was started to see what could be learnt about (implementing) MCD while following the experiences in transdisciplinary groups. All stakeholders (client participants, participants with a professional background, facilitators, local coordinators, management, MCD steering group) were included in the study. They were heard and actively involved in the study to see which steps could (not) be taken next and to check the credibility of our findings.

The study showed that dialogue is not a given once people are brought together and follow a method. From the included examples in our study it was learnt that the characteristics of MCD (confidentiality, mutual openness, vulnerability, equality, postponing judgements, etcetera) may even provoke relational tensions between participants. Despite the focus on equality, the conversation facilitator had to work hard to try to realize this and to take the edge of the dynamics that emerged. Although time and experience helped the client participant to become a full member of the MCD sessions, presuppositions based on stereotypes persisted: THE client, THE caregiver. Incidents resulted in a revival of the initial reticence and fear, thereby opening up the risk of pseudo-participation.

The study taught us that the aspiration of dialogue is not enough once MCD is initiated. MCD implies continuous solid working towards values and norms concerning inclusion, equality, frank speaking and tracking down presuppositions. This conversational attitude requires great courage from the MCD participants, as well as thoroughness in the facilitation of the session. It implies an open search for moments of

tension, relational inconvenience or delicate power issues that are mostly implicit. It also implies an open search for feelings of reticence, fear, discomfiture and latent presuppositions regarding others. In this process, the conversation facilitator needs to employ the characteristics of the MCD practice.

Given these delicate group dynamics, transdisciplinary MCD's challenge the characteristics of MCD itself. If applied strictly, MCD may become an exercise in practising and explicating equality, mutual openness, inclusion. Provided that the MCD sessions are thoroughly facilitated, the practice of MCD can then function as a domain in which participants discover to what extent equality, inclusion and mutual openness are obtainable. Transdisciplinary MCD's can therefore help to construct preconditions for client participation in healthcare in a broader sense.

Chapter 7

General discussion and conclusions

The final chapter of this thesis merges the findings of the former chapters by answering the research questions that were formulated in Chapter 1. What can be learnt from the evaluated process of implementing MCD and what is the role of dialogue in that respect? Combining the findings from the separate chapters constitutes a continuous movement between processes that are based on experiences of all stakeholders in (implementing and researching) MCD, of firm institutionalization and the creation of solid preconditions for (implementing) MCD. The ongoing movement of these three areas calls upon associations with concepts from the political-philosophical work of Hannah Arendt. In her book The Human Condition (1958) she introduces three distinctive stages of the human condition: *Labour*, *Work* and *Action*. We apply the concepts of Arendt as an excurse to shine an extra light on our findings, and to deepen our reflections on the processes that occur in implementing MCD.

In our study, examples of *Labour* come particularly from the local coordinators, who appear to form the backbone of the continuation, motivation, agreements and preconditions of MCD within their teams. *Work* in the implementation process of MCD refers particularly to the role of the manager (initiating MCD, taking care of agreements on who is participating and facilitating time et cetera), and the role of the MCD facilitator (summarized in five tentatively formulated competences of an MCD facilitator that optimize the realization of the normative startingpoints of MCD). *Action* refers to the dialogue as the means and outcome of an MCD session: opening up to unexpectedness in terms of the content of the session and the relational dynamics that come with the process of deliberation. *Action* also refers to the role of the manager, who can settle agreements on organizing MCD (*Work*) yet cannot manage the outcomes of a series of

MCD's. S/he needs to let go as the process evolves and cannot direct predefined aims. MCD can result in concrete working agreements (*Work*) that originate from the deliberative process of MCD and the experiences within it (*Action*). Those agreements need to be processed in regular team meetings (*Work*), after which they can be inserted in regular working processes. For their realization, solid preconditional work is necessary (*Labour*).In other words, the three levels of *Labour*, *Work* and *Action* are continuously interwoven and are present simultaneously in the process of (implementing) MCD. There is no hierarchy between those three concepts: there is an integrated, dynamic relation in which *Labour*, *Work* and *Action* nourish and stimulate each other.

The findings of our study note that dialogue is necessary for implementing MCD in diverse stages of realizing an integrative ethics policy in the organization. Because MCD interferes with local team processes and cultural dynamics (because of its particular characteristics and its relational impact), dialogical exchange of aims and harvest is needed. Not only does this do justice to the sometimes high impact of MCD sessions but it is also in line with our theoretical startingpoints of including experience and work floor expertise in processes that are meaningful. The meaning of MCD can, from a hermeneutical-dialectical perspective, only be understood in direct relation to experiences and the (personal) values that resonate within those experiences. This theoretical perspective on the implementation and practice of MCD coincides with current insights on change management (participative, democratic or transformative management) that aim to actively include employees in processes of change. Ideally, this process is shaped by means of dialogical processes so that all stakeholders can be involved.

A research design that also focused on the realization of a dialogue, inclusion and joint learning appeared helpful in this process. Responsive evaluation created space to share ownership of MCD's practice and implementation and include experiences for a nuanced view on MCD. But at the same time a dialogical implementation process (or its evaluation) cannot do without clear frameworks (*Work*). Those frameworks, that were visible at all levels of the practice of MCD, the implementation of MCD and the research on MCD's, serve safety and zest in the respective processes: for example, via clear agreements, methodical structures, role definition or solid preconditions. If these processes merge and remain interwoven (meaning that agreements come from deliberative processes, and deliberative processes come from changes that are based on agreements, etcetera), they come together in one dialogical practice. Ideally, this process will lead to both top-down and bottom-up involvement, shared ownership and continuous joint learning. This would do justice to the normative starting-points and aims of MCD in practice: Dialogue at Work.